AllCare HEALTH CENTER

PATIENT REGISTRATION FORM

All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.

SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name:_____ Last Name: _____

Preferred Name:_____ Middle Initial: _____

Social Security Number (SSN):_____ Date of Birth (mm/dd/yyyy): _____

Address:_____ City:_____ State:_____ Zip: _____

Preferred Language: _____ Interpreter Needed? ☐ Yes ☐ No

Please fill out any/all contact methods. Check box for preferred **contact method:**

☐ Preferred Phone:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

☐ Alt. Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email Address: _____

Please check which of the following best describes your **sex assigned at birth:**

☐ Male ☐ Female

Please check which of the following best describes your **gender identity:**

☐ Male ☐ Female ☐ Transgender male/ female-to-male ☐ Transgender female/ male-to-female

☐ Choose not to disclose ☐ Don't know/Not applicable ☐ Non-Binary

Please check which of the following best describes your **sexual orientation:**

☐ Straight/heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Something Else

☐ Choose not to disclose ☐ Don't know/Not applicable

Please check which of the following best describes your **preferred pronouns:**

☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir

☐ Decline to answer ☐ Unknown ☐ Other: _____

Please check which of the following best describes your **housing status:**

Are you homeless? ☐ Yes ☐ No

If yes, please describe your housing status:

☐ Homeless shelter ☐ Street homeless ☐ Transitional ☐ Permanent Supportive Housing

☐ Doubling Up ☐ Other homeless:_____

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Please answer the following questions:

Are you a veteran? ☐ Yes ☐ No

Are you a migrant farm worker? ☐ Yes ☐ No ☐ Seasonal

Are you attending school? ☐ Yes ☐ No

If yes, which school are you attending: _____

Please check which of the following best describes **your race.** Please only select

☐ American Indian or Native Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian

☐ Pacific Islander ☐ White ☐ More than one race ☐ Unknown, not listed, or refuse to report

Please check which of the following best describes **your ethnicity.** Please only select one:

☐ Hispanic, Latino, or Chicano ☐ Non-Hispanic, Latino, or Chicano ☐ Refuse to report

Please check which of the following best describes your primary medical coverage type. Please select only one:

☐ Medicaid ☐ Medicare ☐ Private or commercial insurance (including through Marketplace) ☐ None or uninsured

SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **MARK** your family size and household income range (first find family size then find income range in same row)

Family Size:	Annual Income Ranges:					
1	☐ $0 - 12,880	☐ $12,881 - 16,100	☐ $16,101 - 19,320	☐ $19,321 - 22,540	☐ $22,541 - 25,760	☐ Over $25,760
2	☐ $0 - 17,420	☐ $17,421 - 21,775	☐ $21,776 - 26,130	☐ $26,131 - 30,485	☐ $30,486 - 34,840	☐ Over $34,840
3	☐ $0 - 21,960	☐ $21,961 - 27,450	☐ $27,451 - 32,940	☐ $32,941 - 38,430	☐ $38,431 - 43,920	☐ Over $43,920
4	☐ $0 - 26,500	☐ $26,501 - 33,125	☐ $33,126 - 39,750	☐ $39,751 - 46,375	☐ $46,376 - 53,000	☐ Over $53,000
5	☐ $0 - 31,040	☐ $31,041 - 38,800	☐ $38,801 - 46,560	☐ $46,561 - 54,320	☐ $54,321 - 62,080	☐ Over $62,080
6	☐ $0 - 35,580	☐ $35,581 - 44,475	☐ $44,476 - 53,370	☐ $53,371 - 62,265	☐ $62,266 - 71,160	☐ Over $71,160
7	☐ $0 - 40,120	☐ $40,121 - 50,150	☐ $50,151 - 60,180	☐ $60,181 - 70,210	☐ $70,211 - 80,240	☐ Over $80,240
8	☐ $0 - 44,660	☐ $44,661 - 55,825	☐ $55,826 - 66,990	☐ $66,991 - 78,155	☐ $78,156 - 89,320	☐ Over $89,320

SECTION III: INSURANCE INFORMATION

Insurance Name:_____ Policy number/Enrollment ID: _____

Group ID:_____ Member ID: _____

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SECTION IV: FINANCIAL RESPONSIBLE PARTY INFORMATION

First Name:_____ Last Name: _____

Preferred Name:_____ Middle Initial: _____

Social Security Number (SSN):_____ Date of Birth (mm/dd/yyyy): _____

Address:_____ City:_____ State:_____ Zip: _____

Please fill out any/all contact methods. Check box for preferred contact method:

☐ Preferred Phone:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

☐ Alt. Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email Address: _____

Preferred Language: _____ Interpreter Needed? ☐ Yes ☐ No

SECTION V: SHARE OF INFORMATION

I, _____, authorize All Care Health Center's medical and care coordination staff to discuss (share) health or medical information regarding my care with: _____

Patient Signature: _____ Today's Date: _____

SECTION VI: EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to Patient:_____ Phone Number: _____

How did you hear about All Care Health Center? _____

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.

Patient Signature:_____ Date: _____

AllCare HEALTH CENTER

CONSENT TO TREAT FORM

Consent to Routine Treatment

Patient First Name: _____ Patient Last Name: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

Please read and review each section and initial/sign where prompted.

1. Consent for Medical Treatment. I do hereby acknowledge, agree, and give my consent for diagnosis, treatment, behavioral health treatment, dental treatment of me/the patient as deemed necessary by All Care Health Center as indicated appropriate by treating provider, their assistants and/or designees (my "Consent"). I understand that I have the right to refuse treatment and that my signature below is not a consent to non-routine or non-emergent care. This Consent includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory test, x-rays and other routine tests or procedures. In such routine cases, this Consent valid and shall apply to all repeat visits and continuing treatment and diagnosis for such conditions. In other cases, the treating practitioner may ask me to sign a form consenting to specific care, such as surgical procedures. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me/the patient as result to examination and treatment received at All Care Health Center. I acknowledge that my/the patient's care is under the direction of my/the patient's treating provider and the All Care Health Center facility will follow the instructions of my provider(s) in the position in said care.

2. Patient Care. I, the undersigned, agree to uphold my responsibilities to take charge of my/the patient's health care, working with my/the patient's provider and maintaining compliance with my/the patient's providers designated care plan for my/the patient's health and well-being.

3. Personal Valuables. I accept full responsibility for all property in my/the patient's possession. I understand that All Care Health Center maintains no responsibility for property that is personal and in my/the patient's possession.

4. Duration and Scope. I understand this Consent will be valid for one year (12 months) from the date it is signed, unless I revoke it sooner. This Consent will apply to any care provided to me/the patient at any All Care Health Center locations during the next year, unless the care provided requires additional consents by law.

5. Physician and Staff Employment. Some providers at All Care Health Center may be independent contractors who use All Care Health Center facilities to provide care to their patients ("Contractors"). As such, these various independent contractors may submit bills for the professional services they provide separate from the bill All Care Health Center may submit. This Consent extends to such Contractors. Contractors are responsible for their own actions and All Care Health Center Inc. is not liable for their actions or failure to act.

6. Assignment of Benefits. I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to All Care Health Center and its employees or others working under contract or arrangement with it and authorize direct payment to All Care Health Center. For Contractors billing separately from All Care Health Center, I assign coverage and benefits, and direct payment for their services provided to me, to such Contractors. This assignment includes all payments for charges incurred during treatment, visit and observation at all clinics for All Care Health Center and may not be revoked as to the services provided pursuant to this Consent. If there is an overpayment by me or by the insurance carrier, I direct the health center to apply the overpayment to any other unpaid account I/the patient may have with All Care Health Center. A photocopy of this agreement shall be as valid as the original.

7. Assignment of Medicare/Medigap.

Medicare: I request payment of authorized Medicare benefits on my/the patient's behalf for any services furnished to me/the patient by or in All Care Heallth Center. I authorize any holder of medical or other information about me/the patient to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I certify that the information I have provided to All Care Health Center is true, accurate, and complete.

Medigap: I request that payment of authorized Medigap benefits be made on my/the patient's behalf to All Care

Health Center for any services furnished by it to me/the patient. I authorize any holder of medical information about me/the patient to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services. Until revoked, this authorization applies to all occasions of service. This assignment is specific to the supplemental insurance information provided during registration (see scanned copy of the insurance card for policy number).

8. Authorized Representative. I hereby authorize All Care Health Center and its facilities, its agents and representatives to act on my/the patient's behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services it provides to me/the patient.

9. Statement of Responsibility. I understand that I am financially responsible to All Care Health Center as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical insurance deductibles, co-insurance out-of-pocket expenses. I agree to promptly and fully pay All Care Health Center for services and supplies provided to me/the patient at the rates now in effect or to become effective during the course of my care. I agree, subject to state or federal law, to pay all costs, reasonable attorney fees, expenses, delinquent charges and interest, in the event All Care Health Center has to take action to collect the same because of my failure to pay in full. I authorize All Care Health Center to obtain one or more credit reports on me/the patient. No extension or forbearance, no attempt to obtain payment from insurance or other sources and no delay or lack of diligence in collecting such charges shall waive or release the personal financial obligations hereunder.

10. Sliding Fee Discount Program Policy. All Care Health Center has a sliding fee discount program. There is an application process for sliding fee, and eligibility is based on family size, family income, and other special circumstances. I may request more information on the program or a sliding fee application at any time.

11. Self-Payment. I understand I may choose to not have All Care Health Center bill my/the patient's insurance for a particular health care item or service provided to me/the patient, and instead choose to personally pay in full the cost of that health care item or service. To exercise this option, I must notify All Care Health Center in a timely manner, complete additional forms, and pay all applicable charges promptly and in full.

12. Verification of Insurance Information; Release of Information to Insurance Company/Third Party Payer. I certify that the insurance information given by me is correct. I understand that it is my responsibility to notify All Care Health Center of any insurance coverage changes. All Care Health Center may release my/the patient's medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable for all or part of the charges.

13. Pre-Authorization; Non-covered Medicare/Medicaid Services. It is my responsibility to obtain any required pre-certifications or pre-authorizations and/or provide notification of admission as required by my/the patient[s insurance carrier. Not obtaining required certifications/authorizations may mean that my insurance carrier may not cover services that I/the patient receive. In such a case, I understand that I will be responsible personally for the cost of such services provided to me/the patient. The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. All Care Health Center will notify me of anticipated non-coverage. If I agree to proceed with the care, I acknowledge I am financially responsible for all charges incurred.

14. Shadowing and Observation. Some people involved in my/the patient's care may be medical, nursing, or other health care personnel or students in training. I consent to their participation in my/the patient's care. I have the right to request that any of these individuals not participate in or observe my/the patient's care and this request will not affect my/the patient's care at All Care Health Center.

15. Contact by Phone. By providing All Care Health Center with my land line and/or cell phone number(s), I give my express consent for All Care Health Center, its contractors, agents, and collection agents to contact me at these numbers, or at any number that I later acquire, and to leave live or pre-recorded messages or to send text messages. The purposes of such contact may include appointment scheduling, education, telemarketing, debt collection, satisfaction surveys, or other purposes. I understand that for greater efficiency, calls may be delivered by an auto-dialer. If I discontinue use of any cell phone number I have provided, I will promptly notify All Care Health Center of the change. I hereby indemnify All Care Health Center and its agents and independent contractors from any expenses or other loss arising from my failure to notify All Care Health Center of the change.

16. Advanced Instructions for Healthcare. I understand that I/the patient may indicate in writing (Advanced Directions, i.e. Living Will and Durable Power of Attorney) the desire to receive, select, and/or define medical or surgical treatment or choose non-treatment All Care Health Center will recognize such instructions in accordance with applicable Iowa law and the Facility(s) policies if either both Advance Direction statement(s) are provided to the Facility(s) so that a copy is filed with any medical record.

17. Image and Audio Recording Consent. I agree that medical images, photographs, audio recordings and digital or video recordings may be made while I am/the patient is receiving care at All Care Health Center. I understand that the images and audio from such photography and recording may be used for my/the patient's treatment and these images and recordings will become part of my/the patient's medical information subject to uses and disclosures as described in the Notice of Privacy Practices.

18. Participation in HIEs. All Care Health Center participates in CyncHealth (a regional information exchange formerly known as NeHII), which was developed to share information so that participating health care providers can quickly view my health information when caring for me. By signing below, I acknowledge that I have been offered education about CyncHealth, and I understand that patient information will be included in CyncHealth unless I choose to opt out. I can request information on how to opt out.

_____ *Please Initial.* I acknowledge notification of All Care Health Center's Patient Rights and Responsibilities.

_____ *Please Initial.* I acknowledge receipt of All Care Health Center's Privacy Practices.

The undersigned certifies that he or she has read the foregoing, and all questions have been answered. The signee is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Signature: _____ Date: _____

Name of Signee (if not patient):_____ Relationship: _____

Responsible Party's Signature *(if not the same as patient/parent):* _____

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

ARTICLE VII 36.14(1) PHYSICAL EXAMINATION. **Every year each student (grades 7-12) shall present to the student's superintendent a certificate *signed* by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, to the effect that the student has been examined and may safely engage in athletic competition. *This certificate of physical examination is valid for the purposes of this rule for one (1) calendar year. A grace period, not to exceed thirty (30) days, is allowed for expired certifications of physical examination.***

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (Please type or neatly print this information)

Student's Name _____ Male ___ Female ___ Date of Birth _____ Grade _____

Home Address (Street, City, Zip) _____ School District_____

Parent's/Guardian's Name _____ Date _____ Phone #_____

Family Physician _____ Phone # _____

HEALTH HISTORY (The following questions should be completed by the student-athlete with the assistance of a parent or guardian. A parent or guardian is required to sign on the other side of this form after the examination.)

	Yes	No	Does this student have / ever had?
1.	_____	_____	Allergies to medication, pollen, stinging insects, food, etc.?
2.	_____	_____	Any illness lasting more than one (1) week?
3.	_____	_____	Asthma or difficulty breathing during exercise?
4.	_____	_____	Chronic or recurrent illness or injury?
5.	_____	_____	Diabetes?
6.	_____	_____	Epilepsy or other seizures?
7.	_____	_____	Eyeglasses or contacts?
8.	_____	_____	Herpes or MRSA?
9.	_____	_____	Hospitalizations (Overnight or longer)?
10.	_____	_____	Marfan Syndrome?
11.	_____	_____	Missing organ (eye, kidney, testicle)?
12.	_____	_____	Mononucleosis or Rheumatic fever?
13.	_____	_____	Seizures or frequent headaches?
14.	_____	_____	Surgery?
15.	_____	_____	Chest pressure, pain, or tightness with exercise?
16.	_____	_____	Excessive shortness of breath with exercise?
17.	_____	_____	Headaches, dizziness or fainting during, or after, exercise?
18.	_____	_____	Heart problems (Racing, skipped beats, murmur, infection, etc.?)
19.	_____	_____	High blood pressure or high cholesterol?
20.	_____	_____	Head injury, concussion, unconsciousness?
21.	_____	_____	Headache, memory loss, or confusion with contact?
22.	_____	_____	Numbness, tingling or weakness in arms or legs with contact?
23.	_____	_____	Severe muscle cramps or illness when exercising in the heat?
24.	_____	_____	Fracture, stress fracture or dislocated joint(s)?
25.	_____	_____	Injuries requiring medical treatment?
26.	_____	_____	Knee injury or surgery?
27.	_____	_____	Neck injury?
28.	_____	_____	Orthotics, braces, protective equipment?
29.	_____	_____	Other serious joint injury?
30.	_____	_____	Painful bulge or hernia in the groin area?
31.	_____	_____	X-rays, MRI, CT scan, physical therapy?
32.	_____	_____	**Has a doctor ever denied or restricted your participation in sports for any reason?**
33.	_____	_____	**Do you have any concerns you would like to discuss with your health care provider?**

	Yes	No	Family History:
34.	_____	_____	Does anyone in your family have Marfan syndrome?
35.	_____	_____	Has anyone in your family died of heart problems or any unexpected/unexplained reason before the age of 50?
36.	_____	_____	Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?
37.	_____	_____	Has anyone in your family had unexplained fainting, seizures, or near drowning?
38.	_____	_____	Does anyone in your family have asthma?
39.	_____	_____	Do you or someone in your family have sickle cell trait or disease?

*Use this space to explain any **"YES"** answers from above (questions #1-38) or **to provide any additional information**:*

_____

_____

40. Are you allergic to any prescription or over-the-counter medications? *If yes, list:* _____

41. List all medications you are presently taking (including asthma inhalers & EpiPens) and the condition the medication is for:
A. _____ B. _____ C. _____

42. Year of last known vaccination: Tdap (Tetanus): _____ Meningitis: _____ Influenza: _____

43. What is the most and least you have weighed in the past year? ***Most*** _____ ***Least***

44. Are you happy with your current weight? ***Yes*** _____ ***No*** _____ ***If no***, how many pounds would you like to lose or gain?
Lose _____ *Gain* _____

FOR FEMALES ONLY:

1. How old were you when you had your first menstrual period? _____

2. How many periods have you had in the last 12 months? _____

PHYSICAL EXAMINATION RECORD (To be completed by a licensed medical professional as designated in Article VII 36.14(1).

Athlete's Name _____ Height _____ Weight _____

Pulse _____ Blood Pressure _____/_____ *(Repeat, if abnormal _____/_____)* Vision R 20/_____ L 20/_____

	NORMAL	***ABNORMAL FINDINGS***	***INITIALS***
1. Appearance (esp. Marfan's)			
2. Eyes/Ears/Nose/Throat			
3. Pupil Size (Equal/Unequal)			
4. Mouth & Teeth			
5. Neck			
6. Lymph Nodes			
7. Heart (Standing & Lying)			
8. Pulses (esp. femoral)			
9. Chest & Lungs			
10. Abdomen			
11. Skin			
12. Genitals - Hernia			
13. Musculoskeletal - ROM, strength, etc. *(See questions 24-31)*			
14. Neurological			

Comments regarding abnormal findings: _____

_____

_____

LICENSED MEDICAL PROFESSIONAL'S ATHLETIC PARTICIPATION RECOMMENDATIONS

(Please be precise when indicating at which level the student is cleared to participate.)

1. _____ FULL & UNLIMITED PARTICIPATION

2. _____ LIMITED PARTICIPATION - *May **NOT** participate in the following (checked):*

_____ Baseball _____ Basketball _____ Bowling _____ Cross Country _____ Football _____ Golf _____ Soccer

_____ Softball _____ Swimming _____ Tennis _____ Track _____ Volleyball _____ Wrestling

3. _____ CLEARANCE PENDING DOCUMENTED FOLLOW UP OF _____

4. _____ NOT CLEARED FOR ATHLETIC PARTICIPATION DUE _____

_____ _____

Licensed Medical Professional's Name *(Printed)* **Date of PPE**

_____ _____

Licensed Medical Professional's Signature **Phone**

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I hereby **verify** the accuracy of the information on the opposite side of this form and **give my consent** for the above named student to engage in approved athletic activities as a representative of his/her school, except those activities indicated above by the licensed professional. I **also give my permission** for the team's physician, certified athletic trainer, or other qualified personnel to give first aid treatment to my son or daughter at an athletic event in case of injury/illness and to share necessary information about the injury/illness with appropriate school personnel.

_____ _____

Name of Parent or Guardian, or student if 18 years of age *(Printed)* Signature of Parent of Guardian, or student if 18 years of age

_____ _____

Address (Street/PO Box, City, State, Zip) Phone Number

This form has been developed with the assistance of the Committee on Sports Medicine of the Iowa Medical Society and has been approved for use by the Iowa Department of Education, Iowa High School Athletic Association, and Iowa Girls High School Athletic Union. Schools are encouraged NOT to change this form from its published format. Additional school forms can be attached to this form. *08/15*